3 Midlevel Practitioner Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers Medicaid services provided by midlevel practitioners as deemed appropriate by the Department of Health and Welfare (DHW). This includes certified registered nurse anesthetists (CRNA), physician assistants, certified nurse midwives, and nurse practitioners.

3.1.2 Prior Authorization (PA)

If prior authorization for a service is required, the PA number must be included on the claim or the service will be denied.

For Healthy Connections (HC) participants, prior authorization will be denied if the requesting provider is not the primary care provider and a referral has not been obtained.

3.1.3 Place of Service (POS) Codes

Idaho Medicaid follows national place of service codes. Refer to the *Current Procedural Terminology® (CPT) Manual*. Enter the appropriate numeric code in the POS field on the CMS-1500 claim form or in the appropriate field on the electronic claim form.

3.1.4 Reimbursement

Medicaid reimburses midlevel practitioner services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

Idaho Medicaid will reimburse the lowest of the following rates:

- Provider's actual charge for the service.
- Medicaid's established maximum allowable reimbursement from its pricing file for the service. Most mid-level reimbursement is 85 percent of the physician fee schedule as posted on the DHW Web site:

  http://www.healthandwelfare.idaho.gov/DesktopModules/DocumentsSortable/DocumentsSrtView.aspx?tabID=0&ItemID=2727&MId=10587&wversion=Staging
- If a person is eligible for both Medicare and Medicaid, Medicaid's payment for services will not exceed the amount allowed by Medicaid minus Medicare's payment.

3.1.5 Procedure Codes

Idaho Medicaid follows national procedure codes as listed in the most current version of:

- Current Procedural Terminology (CPT).
- Healthcare Common Procedure Coding System (HCPCS).
- International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM).

If a non-specific procedure code is used and the Medicaid medical consultant determines a listed procedure code exists that accurately describes the procedure performed, the claim may be denied.

3.1.6 Tamper Resistant Prescription Requirements

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If Medicaid pays for the drug on a fee-for-service basis, and the prescription cannot be faxed, phoned or electronically sent to the pharmacy, then providers must ensure that the prescription meets all three requirements for tamper-resistant paper.

Any written prescription presented to a pharmacy for a Medicaid participant must be written on a tamper-resistant prescription form that contains all of the following:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Access to care:

The intent of this program is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

3.2 CRNA Services Policy

3.2.1 Covered Services

Medicaid accepts anesthesia codes from the anesthesia section of the *Current Procedural Terminology (CPT) Manual*.

Payments may be made directly to the Certified Registered Nurse Anesthetists (CRNA) under their individual provider numbers when billed on the CMS-1500 claim form or when billing electronically. When a CRNA provides services through hospitals or anesthesiologists groups, the hospital or group may bill Medicaid for the CRNA. Hospitals with a Medicare exception may bill for a CRNA on a UB-04 claim form or bill electronically.

To enroll as a participating CRNA, the hospital or group must send EDS an application with a copy of the valid CRNA license attached.

3.2.2 Anesthesia Time

Anesthesia time begins when the CRNA physically starts to prepare the participant for the induction of anesthesia in the operating room and ends when the CRNA is no longer in constant attendance.

Medicaid does not pay for supervision of anesthesia services. The provider who administers the anesthesia, either a physician or a CRNA, is paid 100 percent of the allowed amount for the procedure.

3.2.3 Billing Instructions

Enter the CPT anesthesia code for the surgical procedure that was performed on the participant, total amount of time in minute increments, and any necessary modifiers from Section 3.2.4 Modifiers.

Idaho Medicaid limits reimbursement for anesthesia procedures to once per day. A repeat anesthesia procedure on the same day which is billed with the CPT modifier **76** or **77** will be paid at $0.00. Medicaid considers that a second separate session of anesthesia has occurred when a patient is returned to surgery after spending time in another unit of the hospital. In these cases, Medicaid will reimburse both CPT anesthesia codes plus the total time for both sessions, with adequate documentation.

3.2.4 Modifiers

Up to four modifiers may be used. No additional payment is made for these modifiers.

Modifier	Description
AA	Anesthesia services personally performed by an anesthesiologist. The -**AA** modifier is used for all basic procedures.
P1	Normal healthy patient.
P2	Patient with mild systemic disease.
P3	Patient with severe systemic disease.
P4	Patient with severe systemic disease that is a constant threat to life.
P5	Moribund patient who is not expected to survive without the operation.
QS	Monitored anesthesia care service (can be billed by CRNA or a physician). This modifier for monitored anesthesia care (QS) is for informational purposes. Please report actual monitoring time on the claim form. This modifier must be billed with another modifier to show that the service was personally performed or medically directed.
QX	CRNA service; with medical direction by a physician.
QZ	CRNA service; without medical direction by a physician.

Modifier **22** should not be used with, or in place of, the appropriate modifier(s) when billing unless the services would require the use of more than three of the modifiers listed above. Make certain that you use the CPT anesthesia code that most accurately describes the procedure performed. The use of modifier **22** overrides any other modifier indicated.

3.3 Physician Assistant, Certified Nurse Midwife, and Nurse Practitioner Services Policy

3.3.1 Overview

State-licensed physician assistants, certified nurse midwives, and nurse practitioners are eligible to participate in the Idaho Medicaid Program. They must obtain an Idaho Medicaid provider number from EDS.

All eligible midlevel practitioners must submit an application for provider enrollment to EDS for approval before billing for services rendered to Idaho participants.

See *Section 1 General Provider and Participant Information,* for more information on provider enrollment.

3.3.2 Misrepresentation of Services

Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other non-physician professional as a physician service is prohibited.

3.3.3 Out-of-state Care

Out-of-state providers who are enrolled in the Idaho Medicaid Program and have an active Idaho Medicaid provider number may render services to Idaho Medicaid participants without receiving out-of-state prior approval.

All medical care provided outside the state of Idaho is subject to the same utilization review, coverage requirements, and restrictions as medical care provided within Idaho.

3.3.4 Medical Policy Restrictions

3.3.4.1 Elective Treatment

Prior authorization is required for all elective medical and surgical procedures. Procedures that are generally accepted by the medical community as medically necessary may require prior authorization to be eligible for payment. To inquire whether a procedure requires prior authorization contact EDS at:

(208) 383-4310 in the Boise calling area

(800) 685-3757 (toll free)

3.3.4.2 Injectable Vitamins

Payment for injectable vitamin therapy must be supported by the diagnosis of pernicious anemia. Injectable vitamin therapy is limited to the following:

- Vitamin B12 and its analogues.
- Vitamin K and its analogues.
- Folic acid.
- Vitamin B12 mixtures, folic acid, and iron salts in any combination.

3.3.5 Coverage Limits

3.3.5.1 Wellness Examinations

3.3.5.1.1 Wellness Physicals - Adults 21 Years and Over:

Adult preventive medicine procedures will be limited to one per rolling year. Evaluation and Management procedures will not be paid on the same day as a preventive medicine procedure for participants over age 21. Preventive Medicine procedures billed for participants over age 21 **must** be billed with diagnosis code

V70.0 – Routine general examination at a health care facility, or the claim will be denied. Bill the appropriate procedure code for the participant's age as listed in the *Current Procedural Terminology (CPT) Manual,* or see codes listed below.

Special reports, and pre-employment physicals for individuals age 21 and older are not covered by Idaho Medicaid.

A health risk assessment/preventive physical examination for an adult that is required by Idaho Medicaid is a covered service. When an exam and/or report is required by DHW for an adult participant, including annual history and physical exams for adults living in an ICF/MR facility, use one of the following two CPT codes with the ICD-9 primary diagnosis code **V70.3 –** Other medical examination for administrative purposes:

- **99450** - Basic Life and/or disability examination that includes: History and Physical and completion of necessary documentation.
- **99080** - Special Reports-more than the information conveyed in the usual medical communications or standard reporting form. This code should be used when the provider can complete the DHW required History and Physical information from past records rather than a new examination.

Wellness codes for adults over age 21:

- **99385 -** New Patient Preventive Medicine Examination – Adult Age 18-39.
- **99386 -** New Patient Preventive Medicine Examination – Adult Age 40-64.
- **99387 -** New Patient Preventive Medicine Examination – Adult Age 65+.
- **99395 -** Established Patient Preventive Medicine Examination – Adult Age 18-39.
- **99396 -** Established Patient Preventive Medicine Examination – Adult Age 40-64.
- **99397 -** Established Patient Preventive Medicine Examination – Adult Age 65+.

3.3.5.1.2 Wellness Physicals for Children up to the Age of 21:

Health risk assessment physicals for children are covered based on the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity requirements. See *Section 1.6 EPSDT,* in *General Provider and Participant Information.* Billing information can be found in *Section 2 General Billing Information*.

Routine physicals such as pre-school, school, summer camp, Special Olympics or sports examinations for individuals up to the age of 21 are covered with diagnosis **V70.3** – Other medical examination for administrative purposes, as long as one of the above reasons is listed on the claim form. The provider must use the preventive medicine procedure codes and diagnosis code **V20.1** – Other infant or child receiving care, or **V20.2** – Routine infant or child health check, when billing for wellness physical exams.

3.3.5.2 Cosmetic Surgery

Cosmetic surgery is not covered by Medicaid unless the surgery is reconstructive and has been prior authorized by DHW.

3.3.5.3 Obesity

Medicaid will only cover bariatric surgeries that are performed in a Medicare-approved Bariatric Surgery Center (BSC) or Bariatric Surgery Center of Excellence (BSCE). A list of facilities approved by Medicare for bariatric surgery is available online from the Centers for Medicare and Medicaid Services (CMS) online at: **http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage**.

Any surgery for the correction of obesity is covered only if prior authorized by the QIO, Qualis Health and with final approval by the Division of Medicaid. If approval is granted, Qualis Health will issue the authorization number and conduct a length-of-stay review.

All participants must meet the criteria for morbid obesity as defined in *IDAPA 16.03.09.431 – 434 Surgical Procedures for Weight Loss*, including:

- The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than 40, or
- BMI equal to or greater than 35 with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities.
- The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition who is not associated by clinic or other affiliation with the surgeons who will perform the surgery.
- The obesity is caused by the serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory or other systemic disease.
- The participant must have a psychiatric evaluation to determine the stability of personality at least 90 days prior to the date a request for prior authorization is submitted to Medicaid.

3.3.5.4 Abdominoplasty or Panniculectomy

Abdominoplasty or panniculectomy is covered only with PA from Qualis Health. Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for prior authorization includes, but is not limited to, the following:

- Photographs of the front, side, and underside of the participant's abdomen.
- Documented treatment of the ulceration and skin infections involving the panniculus.
- Documented failure of conservative treatment, including weight loss.
- Documentation that the panniculus severely inhibits the participant's walking.
- Documentation that the participant is unable to wear a garment to hold the panniculus up.
- Documentation of other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body.

3.3.5.5 Unproven/Questionable Procedures

New procedures of unproven value and established procedures of questionable current usefulness as identified by the U.S. Public Health Service and which are excluded by the Medicare program are excluded from payment by Medicaid.

3.3.5.6 Non-Covered Procedures

The following services are not ever covered by Idaho Medicaid.

- Acupuncture
- Naturopathic Services
- Biofeedback Therapy
- Fertility Related Services
- Laetrile Therapy

3.3.5.7 Complications From Other Non-Covered Procedures

The treatment of complications, consequences, or repair of any excluded medical procedure is not covered. Medicaid may authorize treatment if the resultant condition is determined by Medicaid to be life threatening.

3.4 Emergency Department/Critical Care Services

3.4.1 Overview

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled temporary services to participants who come in for immediate medical attention. The facility must be available 24 hours a day.

Idaho Medicaid limits participants to six emergency department visits per calendar year, unless the participant is enrolled in HC. If the participant is admitted to the hospital from the emergency department this visit is not counted in the six emergency visits per year.

Use codes **99281-99285** to report evaluation and management services provided in the emergency department. No distinction is made between new and established participants in the emergency department.

3.4.2 Critical Care Services

Critical care includes the care of critically ill participants in a variety of medical emergencies that requires the constant attention of the physician or midlevel practitioner. Critical care is usually, but not always, given in a critical care area, such as the Coronary Care Unit, Intensive Care Unit, Respiratory Care Unit, or the emergency care facility.

The following services are included in the global reporting and billing of critical care when performed during the critical period by the physician providing critical care:

- Interpretation of cardiac output measurements.
- Interpretation of chest x-rays.
- Pulse oximetry.
- Blood gases, and information data stored in computers (*e.g.*, ECG, blood pressure, hematologic data).
- Gastric intubation.
- Temporary transcutaneous pacing.
- Ventilator management.
- Vascular access procedures.

The critical care codes are used to report the total duration of time spent by a physician providing constant attention to a critically ill participant.

Use code **99291** for critical care, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injuries or comatose participant, requiring the prolonged presence of the physician. This code is used to report the first 30-74 minutes of critical care on a given day. **99291** is one unit. It should be used only once per day even if the time spent by the physician or midlevel practitioner is not continuous on that day. **99291** is paid to only one physician or midlevel practitioner per day unless the participant is transferred from one facility to another.

Use code **99292** to bill each additional 30 minutes of critical care. This code is used to report each additional 30 minutes beyond the first 74 minutes. Bill code **99292** in 30 minute units.

3.4.3 Other Procedures

Other procedures which are not directly connected to critical care management (the suturing of laceration, setting of fractures, reduction of joint dislocations, lumbar puncture, peritoneal lavage, bladder tap, etc.) are not included in the critical care and should be reported separately.

3.4.4 Prolonged Services

Use codes **99354-99357** when a midlevel practitioner provides prolonged service involving direct (face-to-face) participant contact that is beyond the usual service in an inpatient or outpatient setting.

Use code **99354** or **99356** to report the first hour of prolonged service on a given date, depending on the place of service. Prolonged service lasting less than 30 minutes on a given date is not separately reported, because the work involved is included in the evaluation and management codes.

Use code **99355** or **99357** to report each additional 30 minutes beyond the first hour, depending on the place of service. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

3.5 Obstetric Care (OB)

3.5.1 Overview

Medicaid covers total obstetrical care, including:

- Antepartum care.
- Delivery (certified nurse midwife only).
- Postpartum care.

Obstetric care must be billed as a global charge unless the attending physician did not render all components of the care. Antepartum care may be billed separately from the delivery and postpartum care only when the services were rendered by different group or billing providers

High risk pregnancy case management services are now available to support providers in caring for Idaho Medicaid participants. Pregnant women who are at risk for premature labor or congenital issues of the fetus may be referred to a Qualis Health case manager, who will telephonically assist with the coordination of in-home and community support services. To make a referral:

- Contact Qualis Health at: **(800) 783-9207** and request case management services.
- A nurse case manager will send a packet of information to the participant with information about the voluntary, no-cost service.
- If the participant wishes to participate, she will return the signed form to Qualis Health.

3.5.2 Total OB Care

Total OB care includes cesarean section or vaginal delivery, with or without episiotomy, with or without forceps or breech delivery.

Charges for total obstetric care must be billed after the delivery. The initial office examination for diagnosis of a pregnancy may be billed separate from the total OB charges if that is the provider's standard practice for all OB participants. If the participant is new to the office, a new patient office visit code should be used. The initial examination must be identified as such and billed with the appropriate E/M CPT code.

Prenatal diagnostic laboratory charges, such as a complete urinalysis, should be billed as separate charges using appropriate procedure codes. If an outside laboratory, not the clinic, performed the services, the lab must bill Medicaid directly.

Resuscitation of the newborn infant is covered separately if billed under the child's name and Medicaid identification (MID) number.

3.5.3 Place of Service (POS) Code

The POS code for total OB care is normally **21** – inpatient, and must be on the claim form in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.5.4 Antepartum Care

Antepartum care includes the following usual prenatal services:

- Recording weight, blood pressure, fetal heart tones.
- Routine dipstick urinalyses.
- Maternity counseling.

3.5.4.1 Billing for Incomplete Antepartum Care

If the physician or mid-level sees the participant for part of the prenatal care but does not deliver, submit charges only for the services rendered.

When billing for the initial physical examination and the second or third follow up visit, use the appropriate E/M CPT code. Any laboratory services not previously submitted can be billed using the appropriate CPT procedure code. Do not bill for lab charges sent to an outside laboratory. Bill only for the services rendered.

When billing for four to six prenatal visits, use CPT code **59425** with the total charge for all visits on one line. Do not split-out each visit. Enter the first date of service in the, From Date field on the CMS-1500 claim form or in the appropriate field of the electronic claim form and the last date of service in the, To Date field. Note the date for each visit that falls between the, From Date of service and the, To Date of service in the comment field on the CMS-1500 claim form or in the appropriate field of the electronic claim form. These services must be split out to different claims when the participant is not on the HC program the whole time.

When billing for seven or more prenatal visits with or without an initial visit, use CPT code **59426** with the total charge and the description *Antepartum Care Only* on one line with one charge. Note the date for each visit that falls between the, From Date of service and the To Date of service in the comments field of the CMS-1500 claim form or in the appropriate field of the electronic claim form. These services must be split out to different claims when the participant is not on the HC program the whole time.

3.5.5 Postpartum Care

Postpartum care includes hospital and office visits in the 45 days following vaginal or cesarean section delivery. Postpartum care also includes contraceptive counseling.

3.6 Presumptive Eligibility (PE)/ Pregnant Women (PW)

3.6.1 Overview

The Presumptive Eligibility (PE) and the Pregnant Women (PW) programs are outlined in *Section 1.4.3 Presumptive Eligibility*, and *Section 1.4.4 Pregnant Women, General Provider and Participant Information*. Please refer to Benefit Plan coverage under these sections for more information

3.6.1.1 Billing for PE Determinations

To bill for the completion of a PE determination, follow these procedures:

- Participant and provider complete program questions and determine if participant is eligible for the PE program. Provider sends the application for services to the participant's field office.
- Participant's local field office processes participant's application for services and issues a number for the participant's PE eligibility period.
- Participant's PE period ends after a maximum coverage period of 45 days, or sooner if the candidate is eligible for PW or another Medicaid program.
- Participant's eligibility must be verified by the provider using MAVIS or electronic software. See *Section 1.3.4 Verifying Participant Eligibility*, for instructions.
- Use HCPCS code **T1023** to bill for PE determination.
- Include the participant's full name, Medicaid identification (MID) number and date of birth.

The PE program covers only outpatient ambulatory pregnancy related services. A delivery cannot be billed under the PE program regardless of the setting.

See *Section 1.4 Benefit Plan Coverage* for more information on medical necessity.

A Medical Necessity – Pregnancy Related Form is included in *Appendix D; Forms*.

3.6.1.2 Billing for PE or PW Services

Billings for PE or PW participants should follow the same billing practices as those for any pregnant Medicaid participant.

Services rendered must be a direct result of or directly affect the pregnancy.

Prenatal clinics can bill only the special services procedure codes and laboratory services under the prenatal clinic provider number.

3.6.2 Billing for Twin Deliveries

Delivery of first baby should be billed with the appropriate CPT code, 1 unit, and only the charges for the first delivery. Delivery of the second baby should be billed with a delivery code (**59409**, **59514**, **59612** or **59620**), modifier **51**, 1 unit, and only the charges for the second delivery. All antepartum or postpartum care should be included in the delivery code for the first baby.

3.6.2.1 Medical Necessity Form

The PE and PW programs are for pregnancy-related services only. If the services rendered are not clearly pregnancy related, a Medical Necessity Form which justifies how they are pregnancy related must accompany the claim.

Form Available: A Medical Necessity – Pregnancy Related Form is included in *Appendix D; Forms*.

All services that are not clearly pregnancy related must have supporting documentation to justify the service. Each claim is reviewed on a case-by-case basis by the EDS Medical Consultant. If a claim is

denied with an EOB code that states, *This PW participant's charge has been reviewed by the EDS Medical Consultant and denied*, you can request further review from Medicaid.

Send appeals to:

Division of Medicaid
Medical Care Unit
PO Box 83720
Boise, ID 83720-0036

3.7 Family Planning Services

3.7.1 Overview

Family planning includes counseling and medical services prescribed or performed by a midlevel practitioner. Specific items covered are services for diagnosis, treatment, related counseling, and restricted sterilization.

3.7.2 Contraceptive Supplies

Medicaid will pay for contraceptive supplies including prescription diaphragms, intrauterine devices, implants, injections, contraceptive patches, and oral contraceptives.

3.7.2.1 Limitations

Payment for oral contraceptives is limited to the purchase of a three-month supply when purchased through a pharmacy.

Payment to providers of family planning services is limited to the DHW fee schedule.

Medicaid does not pay a midlevel practitioner for take-home contraceptives, except those inserted or fitted by the provider, such as an IUD, Norplant, or diaphragm.

Note: IUDs are limited to once every rolling five years.

3.7.2.2 IUD

When billing for IUDs, use the following procedure codes (with modifier **FP**):

J7300 Intrauterine copper contraceptive

J7302 Mirena IUD

58300 Insertion of intrauterine device (IUD)

58301 Removal of intrauterine device (IUD)

When billing J codes, the appropriate NDC must be billed with the procedure code.

Note: Medicaid pays for the IUD insertion, but in most cases does not cover the office exam. It is only if the participant was treated for an unrelated diagnosis during that visit that an office exam may be billed at the time of insertion. Attach modifier **25** to the E/M CPT code.

3.7.2.3 Norplant

Norplant contraceptive services must be billed using the following procedure codes (with modifier **FP**):

11975 Insertion, implantable contraceptive capsules

11976 Removal, implantable contraceptive capsules

11977 Removal with reinsertion, implantable contraceptive capsules

J7306 Levonorgestrel (contraceptive) implants system, including implants and supplies (Norplant kit)

3.7.2.4 Depo-Provera and Lunelle Injectables

Depo-Provera and Lunelle injectables must be billed using the following procedure codes (with modifier FP):

J1055 Injection, medroxyprogesterone acetate for contraceptive use, 150 mg (Depo-Provera)

J1056 Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg (Lunelle)

When Depo-Provera is used for any purpose other than contraception or for dosages up to 100 mg, use **J3490** unclassified drug and indicate the NDC (National Drug Code), quantity dispensed, and units of measure. See *Section 3.18.6.3 in the Physician Guidelines* or *Medicaid Information Release MA03-69* for more information.

3.7.2.5 Diaphragms

When billing for a diaphragm, use the following codes (with modifier **FP**):

A4266 Diaphragm for contraceptive use

57170 Diaphragm or cervical cap fitting with instructions

3.7.3 Family Planning Diagnoses/Modifier

Any services provided as part of a family planning visit should include one of the diagnoses listed in the table below as the primary diagnosis. Include the modifier **FP** (family planning) with the CPT E&M code. Using the **FP** modifier with the correct diagnosis saves Idaho Medicaid dollars, and eliminates the need for a Healthy Connection referral.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents)
V25.09	Family planning advice (other)
V25.1	Insertion of intrauterine contraceptive device
V25.2	Sterilization (admission)
V24.40	Contraceptive surveillance, unspecified
V25.41	Contraceptive pill surveillance
V25.42	Intrauterine device (checking, insertions, or removal of device) surveillance
V25.43	Implantable subdermal contraceptive surveillance
V25.49	Surveillance of other contraceptive method
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other unspecified contraceptive management (post-vasectomy sperm count)
V25.9	Unspecified contraceptive management

3.8 Child Wellness Exams

Complete information regarding child wellness exams is located in *Section 1.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), General Provider & Participant Information*. Sometimes child wellness exams are referred to as *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens*.

3.9 Other Billing Procedures

3.9.1 Consultations

A consultation is a type of service provided by a physician assistant whose opinion or advice regarding evaluation and/or management of a specific problem is requested by a physician or other appropriate source. A physician assistant consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

The written or verbal request for a consultation from the attending physician or other appropriate practitioner and the need for the consultation must be documented in the participant's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant's medical record and communicated by written report to the requesting physician or other appropriate source.

If a consultant subsequently assumes responsibility for management of a portion or all of the participant's condition(s), the follow-up consultation codes should not be used. In the hospital setting, the physician assistant receiving the participant for partial or complete transfer of care should use the appropriate subsequent hospital care codes. In the office setting, the appropriate established participant code should be used

Note: Phone consultations are not a payable service by Medicaid.

3.9.2 Assist at Surgery

In order to recognize assistant at surgery services provided by a physician assistant or nurse practitioner (mid-level practitioners), surgical codes should be billed with modifier **AS**.

AS Physician Assistant or nurse practitioner services for assistant-at-surgery (Medicare Part B bulletin GR99-3)

Note: All unlisted CPT codes must have a description on the claim form.

3.9.3 Foster Care

Program enrollment physicals for foster children are eligible for payment by Medicaid as a child wellness exam. See *Section 1.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), General Provider & Participant Information*, for billing guidelines.

3.9.4 PKU Testing

Newborn Screening Kits (PKU) are a covered benefit of the Idaho Medicaid Program. Test kits are ordered through the Idaho Newborn Screening Program and must be purchased in advance from:

Idaho Newborn Screening Program
450 West State Street, 4th Floor
PO Box 83720
Boise, ID 83720-0036
(208) 334-4927 in the Boise calling area

Bill Idaho Medicaid with procedure code **S3620.**

3.9.5 Collection Fees

Collection of a lab specimen for a participant is not payable in an office setting.

3.9.6 Allergy Injections

Office calls are included in the reimbursement for allergy injections.

3.10 Immunizations

3.10.1 Immunization Program

3.10.1.1 Overview

Most vaccines provided come through the Vaccines for Children (VFC) Program from the Department of Health and Welfare's Division of Health. However, on limited occasions, the provider must purchase vaccines. Vaccine administration should conform to the Advisory Committee on Immunization Practices (ACIP) guidelines for vaccine use.

When billing for a participant who has both private insurance and Medicaid, bill the private insurance first using its billing instructions. After receiving the EOB from the primary insurance indicating partial or no payment, submit the EOB with the claim to Medicaid using the instructions below. All vaccine services should be billed at the usual and customary rate providers use to bill for non-Medicaid participants.

Vaccine Services Provided	Billing Instructions For Children (The free vaccine program is available for participants until their 19th birthday.)	Billing Instructions For Adults (Free vaccine is not available for those who have reached their 19th birthday.)
Administration of free vaccine only:	Bill the appropriate CPT code for the vaccine(s) using *modifier **SL*** with a zero dollar ($0.00) amount; and The CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine(s).	Not applicable – there is no free vaccine program for adults
Administration of free vaccine and, if there is a *significant*, separately identifiable service, Evaluation and Management (E&M) visit:	Bill the appropriate CPT code for the vaccine(s) using *modifier **SL*** with a zero dollar ($0.00) amount; and The CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine(s), and The appropriate CPT code for the E/M visit with *modifier **25***.	Not applicable – there is no free vaccine program for adults
Administration of provider-purchased vaccine only:	Bill the appropriate CPT code for the vaccine(s) *without* a modifier, and The CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine.	Bill the appropriate CPT code for the vaccine(s) *without* a modifier, and The CPT code in the range of **90471** to **90474** that accurately reflects the administration of the vaccine.
Administration of provider-purchased vaccine, and, if there is a *significant*, separately identifiable service, Evaluation and Management (E&M) visit:	Bill the appropriate CPT code for the vaccine(s) without a modifier, and The CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine, and if applicable, The appropriate CPT code for the E/M visit with *modifier **25**.*	Bill the appropriate CPT code for the vaccine(s) without a modifier, and The CPT code in the range of **90471** to **90474** that accurately reflects the administration of the vaccine, and if applicable, The appropriate CPT code for the E/M visit with *modifier **25**.*

3.10.1.2

3.10.1.3 Administration of an Injection that is Part of a Procedure

When an injection is administered that is part of a procedure (i.e. allergy injections, therapeutic and diagnostic radiology, etc.), Medicaid will not pay the administration fee(s).

3.10.1.4 Administration Only of a Injectable/Vaccine to a Participant with Medicare or Other Primary Payer and Medicaid

When billing for a participant who has either Medicare or private insurance, and Medicaid, bill Medicare/private insurance first using its billing instructions. If Medicare or the other primary payer combines payment for the administration with the cost of the injectable, a separate administration fee may not be charged.

3.10.1.5 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes

Professional claims for medications reported with HCPCS codes, must include the appropriate NDC of the medication supplied, units dispensed, and basis of measurement for each HCPCS medication. The NDC will be listed on the product label/packaging. This requirement applies to cancer drugs with HCPCS codes, claims submitted electronically and on the paper CMS-1500 claim form.

The HCPCS medications that require NDC information are listed in the current *Healthcare Common Procedure Coding System (HCPCS) Manual, Appendix 3*, alphabetically by both generic, brand or trade name, with corresponding HCPCS codes. Claims with incomplete NDC information will be denied with EOB 628 – NDC Required.

The collection of the NDC information is a Federal requirement for all Medicaid Programs that allows Medicaid to collect rebates due from drug manufacturers. This results in a significant cost saving to Idaho's Medicaid Program.

Electronic Claims: For professional providers that use the PES billing software (provided by EDS at no cost), HIPAA compliant fields to report the NDC information are available. Providers who are not set up to bill electronically with PES software may contact an EDS at:

(800) 685-3757 (toll free)
(208) 383-4310 in the Boise calling area

To enter NDC data in the PES software, complete the Service and RX tab fields using the following guidelines:

SERVICE Tabs:

Step 1 Complete Service Tabs 1 and 2 as appropriate.

Step 2 Select Service Tab 3 and complete the appropriate fields.

Step 3 Enter, Y in the RX Ind field to open the RX tab.

RX Tab:

Complete the following fields:

- NDC: enter the 11-digit NDC number. **Note:** The NDCs are arranged in the 5-4-2 digit configuration. The first 5-digits identify the manufacturer, the middle 4-digits identify the product, and the last 2-digits identify the package size. Let zeros fill in appropriate areas to conform to the 5-4-2 configuration.
- Prescription Number: not required.

- Units: Enter the units dispensed. Refer to the *Healthcare Common Procedure Coding System (HCPCS) Manual*, *Appendix 3*, for directions regarding the, Amount (Unit) column.
- Basis of Measurement: Enter IU – International Units, GR – Grams, ML – Milliliters, or UN – Unit.
- Unit Price: enter the price for the HCPCS medication dispensed.

See the *Provider Electronic Solution (PES) Handbook, Section 9 (837 Professional Forms)* for more information on completing the Rx fields. It is available on the *Idaho Medicaid Provider Resources CD*.

Providers using vendor software other than PES will need to confirm with their vendor or clearinghouse that they have successfully tested the professional claim form with EDS and can successfully enter the required data into the correct fields (NDC of medication supplied, units dispensed, and basis of measurement for each HCPCS medication).

Paper Claims: Submission of an NDC Detail Attachment is required with paper claim forms when submitting a medication billed with a HCPCS code. For each medication HCPCS code, complete the corresponding detail line on the attachment with the NDC number, description, units dispensed, basis of measurement, and total charges. A copy of the NDC Detail Attachment is available in *Appendix D; Forms* at the following Web site:

http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3438/DesktopDefault.aspx

Providers can avoid filling out the NDC Detail Attachment by submitting their claims electronically.

3.11 Claim Billing

3.11.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.11.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solution (PES) Handbook.* Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission* for more information.

3.11.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral Number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on electronic HIPAA 837 Professional transactions.

Diagnosis codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) information with HCPCS and CPT codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3* in the *Physician Guidelines* for more information.

Electronic crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.11.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006

3.11.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean; use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format; note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field **24A**.
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.
- A maximum of six line items per claim can be accepted; if the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements; total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one prior authorization number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim.

3.11.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.11.3.3 Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

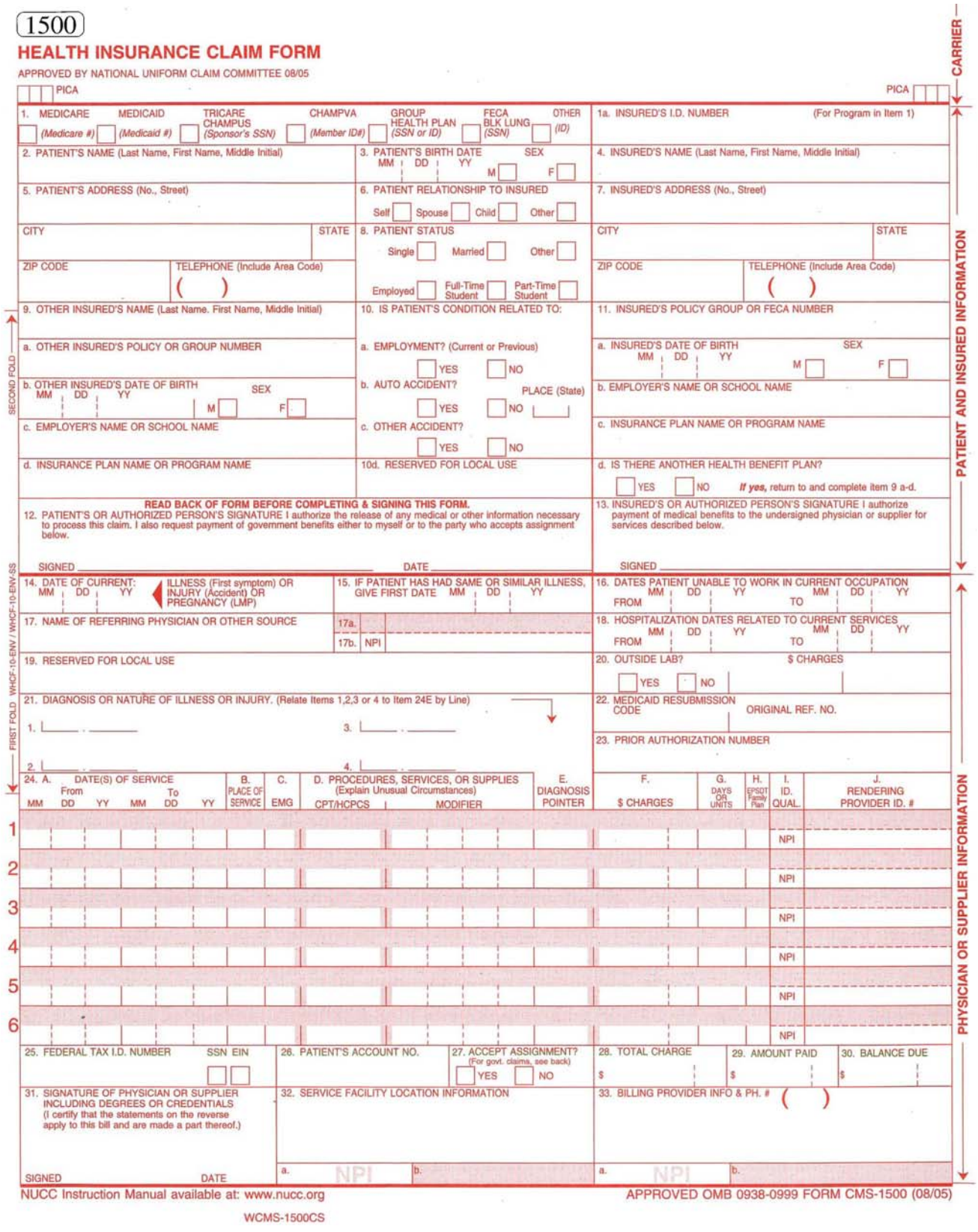
Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Patient's Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Is Patient's Condition Related to Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Is Patient's Condition Related to Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a-9d**.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness Give First Date	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	Blank Field	Required if applicable	Use this field when billing for consultations or Healthy Connections participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For Healthy Connections participants, enter the qualifier **1D** followed by the 9-digit Healthy Connections referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI Number	Not Required	Enter the referring provider's 10-digit NPI number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.

Field	Field Name	Use	Directions
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24D 1	Procedure Code	Required	Enter the appropriate five character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield **(1-4)** for the diagnosis code entered in field **21**.
24F	Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, see section 1.6 EPSDT, for more information.
24I	ID. Qualifier	Required if Legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID Number	Required if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID Number field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form* for more information.
33	Billing Provider Name, Address, & Phone Number	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or RA. **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33A	NPI Number	Desired but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.

Field	Field Name	Use	Directions
33B	Other ID	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.11.3.4 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS